Kansas Department of Health and Environment

Adult Care Home Program

FACT SHEET

Volume 19, Number 3 www.state.ks.us/public/kdhe/bacc/ **July 1998**

In this issue....

The federal is published by the Kansas Department of Health and Environment.

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Privacy Act Statement

The Health Care Financing Administration has determined that Medicare/Medicaid certified facilities must provide residents with a statement concerning the submission of the Minimum Data Set to the Health Care Financing Administration repository. Enclosed with this issue of the *Fact Sheet* is a statement which facilities may use to fulfill this requirement. Providers may request to have the Resident or their Legal Representative sign a copy of this notice as a means to document that notice was provided. A signature is **NOT** required. If the Resident or their Legal Representative agrees to sign the form, it merely acknowledges that they have been advised of the information. Residents or their Legal Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

Currently, Kansas is collecting MDS data for the Multistate Case Mix and Quality Demonstration. A systems notice was issued by the HCFA which allowed for this process. With the change to the federal system and the completion of the demonstration project, all Medicare/Medicaid facilities must issue the privacy statement to current residents and to new residents admitted on and after June 22 ,1998.

Implementation of the Federal MDS Automation System

The Federal Automation system for the MDS will be implemented on June 22, 1998. All assessments with a reference date of June 21, 1998 and before must be submitted to the bulletin board system at Myers and Stauffer. Assessments with Assessment Reference Dates of June 22 and after must be submitted to the Federal system using the 1.30.98 version of the MDS 2.0.

Facilities which chose not to send staff to the automation training sessions may obtain a copy of the MDS AUTOMATION MANUAL by contacting the Myers and Stauffer help desk at (785) 228-6770. This manual will provide information on how to set up a transmission system to the Federal automation system.

The Help Desk at Myers and Stauffer is a resource for facility staff in

obtaining facility specific information. It is recommended that facilities send a test file (one or two records) to the federal system prior to submitting a production file. Directions for sending test transmissions can be found in the manual distributed at the trainings.

Prospective Payment System for Medicare Certified Skilled Nursing Facilities

As part of the implementation of the Balanced Budget Act of 1997, Medicare certified skilled nursing facilities will migrate to a prospective payment system (PPS) beginning July 1, 1998. The date of implementation of PPS in a Medicare facility is dependent on the start of their fiscal year on and after July 1, 1998. All Medicare certified skilled nursing facilities should attend trainings conducted by their Medicare fiscal intermediary (F.I.). Any facilities which have not received information concerning these trainings should contact their F.I. immediately.

In preparation for the PPS system, the MDS 2.0 has been revised. Included with this issue of the *Fact Sheet* are copies of Section A.8. Reasons for Assessment and Section T. Therapy Supplement for Medicare PPS. Software vendors received information concerning these changes in April. In addition, the software used by a Medicare certified skilled nursing facility must be able to calculate the Resource Utilization Groups (RUG's) for Medicare. Please note that all Medicare and Medicaid certified facilities in Kansas must complete Section T. Therapies and Section U. Medications.

The prospective payment system requires additional assessments for all residents whose source of payment is Part A Medicare. Attached to this issue of the *Fact Sheet* is a review of the reasons for assessments. At this time, this agency has not received an official copy of the operational definitions for the required Medicare assessments from the Health Care Financing Administration. Questions related to the submission of the MDS for the PPS should be directed to the facility's fiscal intermediary.

CREDENTIALING UPDATE

Pat Dismukes to Retire

Congratulations to Ms. Patricia Dismukes, Bureau of Adult and Child Care, who will retire from public service on September 4, 1998. Ms. Dismukes, an employee of KDHE (and the former Kansas Board of Health) for more than twenty years, has primarily held administrative duties within adult health care programs.

Ms. Dismukes helped develop the procedures for certifying nurse aides, licensing of adult care home administrators, and more recently has administered the licensing of speech-language pathologists, audiologists, dietitians in addition to providing staff support to the Kansas Board of Adult Care Home Administrator.

The bureau will miss Pat and wishes her well in her future endeavors!

Long-term Sponsorships to be Offered

The pilot sponsorship program for nurse aide, home health aide and medication aide training programs began in 1996. Sixteen sponsors participated in the pilot which is now being concluded.

Beginning August 1, 1998, the Credentialing Unit will administer a sponsorship program for aide-type training programs. The participants of the pilot and administrators at HOC have modified the terms of the program slightly, but it will offer the same benefits with more reduction in "paperwork." This program allows, through an approval process, sponsors to submit the terms of the type of training program(s) being offered only once, with periodic submission of other items prior to the date the course is actually offered (such as the instructor, times, dates). The pilot showed significant savings in time and effort. Although the department originally intended to offer this program with a fee attached, no charge will be made at this time.

If you have questions, please contact Martha Ryan (785) 296-0058 or Heidi Collins (785) 296-6796.

New Waiver Process for Facilities with a Ban on Training

In May 1997 the Social Security Act was amended to allow the possibility of a waiver of the 2-year prohibition on Nurse Aide Training and Competency Evaluation Programs (NATCEP). This would allow a NATCEP to be held in (***not by***) certain nursing homes if these three criteria are met:

- there is no other such program offered within a reasonable distance of the facility (defined as within ½ hour of the facility)
- through an oversight effort, an adequate environment exists for operating the program in the facility; and,
- notice of such determination and assurances will be provided to the State long term care ombudsman.

In absence of Final Federal Regulation, the HCFA regional office in Kansas City put together a task force to develop criteria for interpreting the law for granting a waiver. In order for Kansas to meet the new criteria, the current exception process was modified.

As before, the application must be submitted by an eligible sponsor, but now the form has two parts. One is filled out by the facility the other by the sponsor. Both are submitted together with an Application for Approval of Training Course.

New items on the sponsor's section include: describing the process used to determine an adequate teaching/learning environment exists for the course, specifying whether the instructor is an employee of the clinical site and/or course sponsor, submitting the evaluations within 10 days of course completion, providing the instructor and the students information on how to register concerns with the state agency, and agreeing to allow unannounced site visits.

New items on the facility's form include: submitting documentation of current survey status, specifying if the facility has been deemed a poor performing facility, and documenting that there are no other courses available within a reasonable distance.

Requests for Exceptions/Waivers on the old forms will no longer be accepted after June 15, 1998. For a packet containing the forms and the educational tool, please call Health Occupations Credentialing at 785-296-0056.

Changes in Abuse, Neglect and Exploitation Statutes

House Bill 2185 was passed and signed into law on May 18, 1998 by Governor Bill Graves. This bill contains several amendments to the adult, neglect and exploitation statutes which will impact adult care homes.

The definitional changes are being evaluated by the department at the present time. Additional information related to these changes will be in later issues of the *Fact Sheet.*

Semi-Annual Report

Enclosed with this *Fact Sheet* is the Adult Care Home Semi-Annual Report, January 1, 1998 through June 30, 1998, Form KDHE 400. This form should be completed by all nursing facilities, assisted living facilities, residential health care facilities and nursing facilities for mental health. Form KDHE 401 (Adult Care Home Semi-Annual Report for ICF/MRs) is to be completed by all intermediate care facilities for the mentally retarded.

The Adult Care Home Semi-Annual Report should be filed with the Bureau of Adult and Child Care by **July 15, 1998**. Please note the reporting period for Resident Census and Staffing in the Semi-Annual report is the week of March 22-28, 1998. When reporting "Hours Actually Worked" indicate the hours in **whole** numbers only.

Mail to: Semi-Annual Report
BACC/KDHE
900 SW Jackson, Suite 1001
Landon State Office Building
Topeka, KS 66612-1290

RESOURCES FOR QUALITY CARE

FOCUS ON FOOD SAFETY, Food and Drug Section Kansas Department of Health and Environment, 1997.

The challenge of preparing quality safe food begins with well trained and knowledgeable food service workers. This educational material is designed to help meet that challenge by focusing on those items that are critical to the safe preparation, cooking, holding and storage of food. It clearly and concisely identifies and discusses the basics that will help prevent food borne illnesses. Order copies from the Bureau of Environmental Health Services, 109 SW 9th, Suite 604, Topeka, KS 66612-1274, (785) 296-0189.

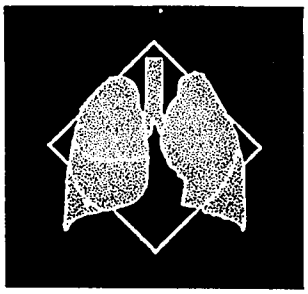
ANE ISSUE STATISTICS 3/1/98 to 5/31/98
Complaint Calls Assigned for Investigation

ANE Investigations		Care Issues Investigated	
Total	428	Total	357
Mar	132	Mar	119
Apr	158	Apr	119
May	138	May	119

*Licensure Category	Civil Penalties				Correction Orders			
	1998 Quarters							
	1st	2nd	3rd	4th	1st	2nd	3rd	4th
Inadequate or inappropriate hygiene and skin care	8				38			
Inadequate or unqualified staffing	10				35			
Inoperable or inaccessible call system	-				-			
Inappropriate or unauthorized use of restraints	-				6			
Unsafe medication administration or storage	1				10			
Inadequate nursing services other skin care	8				54			
Inadequate or inappropriate asepsis technique	-				6			
Inadequate or inappropriate dietary/nutritional services	-				3			
Unsafe storage or hazardous or toxic substances	-				1			
Failure to maintain equipment	2				7			
Resident right violations	6				25			
Unsafe high water temperature	-				-			
Inadequate hot water	1				-			
General sanitation and safety	2				14			
Other (including inappropriate admission)	6				18			
Inadequate rehabilitation services	-				-			

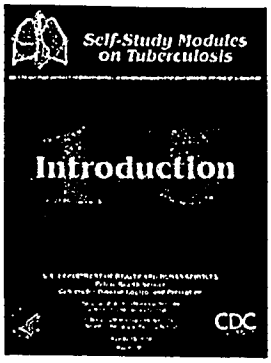
Civil Penalties	30	
Correction Orders		110
Bans on Admission		2
Denials		0

***A correction order or civil penalty may consist of** multiple issues summarized within the licensure categories above.



Nurse Alert!

Earn 24
Continuing Nursing Education Units (CNEs)
(Free of Charge)



Self-Study Modules on TB

This course is a set of 5 educational modules designed to provide basic information about TB in a self-study format.

You will cover these topics:

- **Transmission and Pathogenesis of TB**
- **Epidemiology of TB**
- **Diagnosis of TB Infection and Disease**
- **Treatment of TB Infection and Disease**
- **Infectiousness and Infection Control**

Take the course yourself or share this information with your co-workers.

The Self-Study Modules on TB course is approved for 24 CNEs or 2.0 CEUs.

How to Register:

Contact the CDC's Public Health Training Network, 1-800-41-TRAIN

Study independently or organize and facilitate a study group. If you are interested in becoming a group leader, call 1-800-41-TRAIN, then select option 5.

If you do not want to register for CNEs or CEUs, but would like to request a copy of the Self-Study Modules on TB as a resource, call the CDC Voice and FAX Information System toll free (888-232-3228), then select 2, 5, 1, 2, 2, 2, and request: "Self Study Modules on Tuberculosis," Order #00-6514.

KANSAS TB EDUCATION

New staff needs tuberculosis orientation? Not too sure about administering or reading a Mantoux tuberculin skin test? Education programs of 1-3 hours at no charge are available to meet your need. Call the TB Nurse Consultant, Allison Alejos, RN, (785) 296-2547 to make arrangements. Kansas Department of Health & Environment, TB Control, Topeka, Kansas

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE THE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. Authority for collection of information including social security number (SSN)

Sections 1819 (f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Skilled nursing facilities for Medicare and Medicaid are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity and health status. As of June 22, 1998 all skilled nursing and nursing facilities are required to establish a database of resident assessment information and to electronically transmit this information to the State. The State is then required to transmit the data to the federal Central Office Minimum Data Set (MDS) repository of the Health Care Financing Administration.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long Term Care System of Records.

2. Principal Purposes For Which Information is Intended to Be used

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing homes that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing homes to receive reimbursement for Medicare services.

3. Routine uses

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1516. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at request of that individual; (2) the Federal Bureau of Census; (3) the Federal Department of Justice; (4) an individual or organization for research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

4. Whether disclosure is mandatory or voluntary and effect on individual of not providing information.

For nursing home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If a nursing home does not submit the required data it cannot be reimbursed for any Medicare/Medicaid services.

Section A. 8 Reasons for Assessment

This section of the MDS has been revised to accommodate the assessments required for the Medicare Prospective Payment System. Below is a summary of the changes to this section of the MDS.

1. Admission assessment.	Unchanged. A comprehensive assessment (MDS + RAPs) must be completed by day 14 of admission. VB2 date should be withing 14 days of admission.
2. Annual assessment.	Unchanged. VB2 date should be within 366 days of previous comprehensive assessment.
3. Significant change in status	Unchanged. A comprehensive assessment should be completed within 14 days of determination that a significant change has occurred. VB2 date should be within 14 days of the determination.
4. Significant corrections of prior full assessment	Unchanged. It has been determined that the previous comprehensive assessment did not reflect the resident. A new assessment must be completed to ensure that the care plan accurately reflects the resident's needs. An incorrect assessment could also affect the payment codes for Medicaid and Medicare certified facilities. VB2 date should be within 14 days of the determination of the need for significant correction.
5. Quarterly review assessment	This item includes a quarterly review assessment using full MDS form. Medicare and Medicaid certified facilities will use this item for 90 day assessments (provided the assessment is to be used to meet HCFA's quarterly clinical requirement). RB2 date should be within 92 days of previous assessment. **NOTE:** In the event, it is determined that the resident has experienced a significant change in condition, the assessment would be coded as a "3" because RAPs will be reviewed and recorded on

6. Discharged-return not anticipated.	This code is used using the discharge tracking system to indicate that the resident has been discharged from the facility and is not expected to return. R4 date must be the date the resident was discharged from the facility. Record at R3 the disposition of the resident.
7. Discharge-return anticipated.	Resident has been transferred to a hospital or other health care facility for more than 24 hours and is expected to return. Record date that the resident left the facility at R4 and indicate at R3 the type of health care facility was admitted to.
8. Discharge prior to completing initial assessment.	Resident was discharged or died prior to completion of the initial assessment. See discussion below concerning this choice.
9. Reentry	This item indicates that the resident has returned from a hospital stay or a stay in another therapeutic setting. Record at A4a the date of reentry to the facility.
10. Significant correction of prior quarterly assessment.	Most recent quarterly assessment has been determined to be incorrect. A new assessment will be performed using a new assessment reference date. The date coded at R2b must be within 14 days of the determination that the previous quarterly assessment was incorrect.

The HCFA sequencing system will use assessments 1, 2, 3, 4, 5, and 10. (The HCFA record sequencing system uses assessments as well as Discharge and Reentry tracking forms). The above codes will enter the state system and determine when a new assessment is required to be submitted. Codes 6, 7, 8 indicate that the resident has either been discharged or is out of the facility. When codes 6 and 8 are used, the MDS record for this resident will be closed. Code 8 is to be used to indicate that a resident was discharged prior to the completion of the initial admission assessment. In the event, the resident returns to the facility, a reentry form must be completed and a new admission completed with a new assessment reference date.

When a resident is discharged (transferred) to the hospital or another therapeutic setting for

treatment and is expected to return to the facility, complete the discharge tracking form and use code 7. When the resident returns, a tracking form must be completed. Code reason for assessment as "9" reentry. In the event the resident decides not to return to the facility or dies while away from the facility, a tracking form must be completed which indicates that the resident was discharged and not expected to return. Enter the date the facility was notified that the resident died or had decided not to return. All entries to the discharge tracking system are to be included in transmissions to the state data base.

Section B. Codes for Medicare PPS

Facilities which participate in the Medicare program will be required to perform MDS assessments according to the current Federal schedule and in addition perform three additional assessments, 5 day, 30 day and 60 day assessments. There will be instances when an assessment will be performed to fulfill requirements for the resident's stay under Medicare and also to meet the clinical requirements found in 42 CFR 483.20. Staff encoding the MDS should review the following information very carefully. The codes will used for residents whose payor source for is Medicare Part A. It is very important that assessments are submitted to the state data base in the correct sequence.

NOTE: **The day of admission is counted as day 1.** This is a change in instructions from the current manual instructions. This change affects assessments performed for residents whose payor source is Medicare Part A.

1. Medicare 5 day assessment.	The Medicare 5 day assessment maybe completed without a review of the RAPs. Code 8.A = 0 and 8.B = 1 Facilities also have the choice of completing the RAP review with the 5 day assessment. Code 8.A=1 and 8.B = 1
2. Medicare 30 day assessment	Code 8.A = 0 and 8.B = 2 **OR** 8.A = 5 and 8.B = 2 (if this assessment is to be considered a quarterly for the HCFA clinical schedule)
3. Medicare 60 day assessment	Code 8.A = 0 and 8.B = 3 **OR** 8.A = 5 and 8.B = 3 (if the assessment is to be considered a quarterly for the HCFA clinical schedule)

4. Medicare 90 day assessment	Code 8. A = 5 and 8.B = 4
5. Medicare readmission/return	Code 8. B = 5. This assessment must be completed in same time frame as the 5 day assessment. Each time a Medicare resident returns from a hospital stay, the Medicare schedule of assessments begins again at day 5. In most instances the resident will have experienced a significant changed in condition. Therefore a significant changed in condition assessment will need to be completed by day 14. Codes as 8.A = 3.
6. Other state required assessment	At this time, this code will not be used in Kansas.
7. Medicare 14 day assessment	Code 8.A = 0 and 8.B = 7 if the five day Medicare assessment included completion of Section V (RAPs and care planning) **OR** code 8.A = 1 and 8.B = 7 for a 14 day Medicare assessment which includes completion of Section V.
8. Other Medicare required assessment	Code 8.A = 5 and 8.B = 8 when a resident's rehabilitation therapies have been discontinued and the resident is not able to be discharged from the facility. Complete a comprehensive assessment (MDS + RAPs). The next assessment for this resident will be due in 92 days unless a significant change occurs.

* The HCFA system software at Myers and Stauffer does not automatically include the Medicare assessments coded in Section b in the sequencing system. Facilities must develop procedures which ensure that an admission assessment is coded for all residents whose stay is 14 or more days. A quarterly assessment must be performed and coded as A 8 a = 5 for all residents whose stay in the facility is 90 days or more. There maybe a problem in keeping track of the quarterly review for those residents who are admitted to the Medicare section of the facility after first being admitted to a non-Medicare bed and those residents who are readmitted to the facility after one or more hospital stays during one admission to the facility. Quarterly assessments may be performed earlier than 90 days. HCFA has given facilities some latitude in coding and completing assessments. It is very important that the staff review the directions for coding provided by the Medicare fiscal intermediary.

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER⊙	1. Male 2. Female
3.	BIRTHDATE⊙	Month — Day — Year
4.	RACE/⊙ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY⊙ AND MEDICARE NUMBERS⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.⊙	a. State No. b. Federal No.
7.	MEDICAID NO. [*"+" If pending, "N" If not a Medicaid recipient]⊙	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
9.	SIGNATURES OF PERSONS COMPLETING THESE ITEMS:	
a.	Signatures	Title Date
b.		Date

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊙ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered (**for at least 15 minutes a day**) in the **last 7 days** (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = # of days administered for 15 minutes or more		
(B) = total # of minutes provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered. ☐☐

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered? ☐☐☐☐

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:
- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare ☐☐☐☐☐ **State** ☐☐☐☐☐